

ILAPSC 2026 CONFERENCE

Using Contingency Management for Substance Use Disorders Treatment

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Learning Objectives

1. Attendees will be able to identify the three fundamental principles that underly successful contingency management interventions.
2. Attendees will be able to describe appropriate target behaviors to reinforce using contingency management in the context of a substance use disorder.
3. Attendees will be able to summarize the key issues when developing and implementing contingency management interventions that are critical to navigate to ensure the intervention's fidelity and efficacy.

Financial Disclosure: Dr. Weinstock has no conflict of interest to declare in relation to this presentation. He has no financial interest in any products highlighted in this presentation. His research has been funded by the National Institutes of Health, the International Center for Responsible Gaming, and the Stamm Koechlein Family Foundation.

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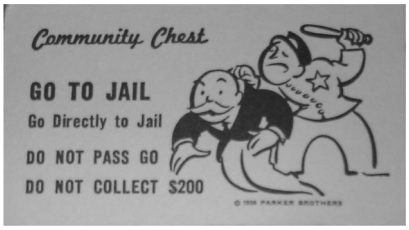
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Historically How Our Society Treats Substance Users



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Background on CM

Current punishers in SUD treatment:

- Discharge for using substances
- Inform probation officer
- Lower methadone dosage



Current reinforcers in SUD treatment:

- AA: coins, coffee, social interaction
- Treatment programs: certificates, praise, take home methadone bottles.



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Background

Why are these punishers and reinforcers ineffective?

- Often, behaviors are not specifically defined.
- Same punishers and reinforcers used for a variety of behaviors.
- Consequences are not applied for each instance of behavior.



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Fundamental Principles of CM

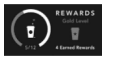
Three central tenets of effective Contingency Management (CM) interventions:

1. Frequently ***monitor*** a specific target behavior.
2. Provide tangible positive reinforcement ***each time*** the target behavior is demonstrated.
3. ***Withhold*** positive reinforcement if the target behavior does not occur. Can add in a slight punisher

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Is Offering Rewards Really Novel?

- Every day ***positive reinforcement*** increases the probability of a behavior.
  - Consumer Behavior
    - 5% Cashback, Starbucks Rewards
  - Employees
    - Salaries, commissions, awards, social praise
  - Children
    - Star charts, special foods, allowance
  - Pets
    - Treats





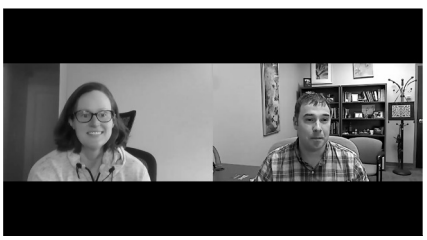






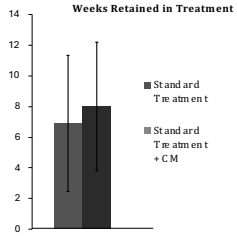

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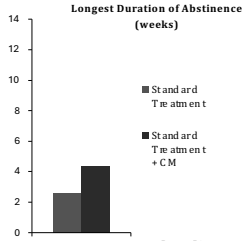
Example of a Typical CM Session



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Clinical Trials of CM

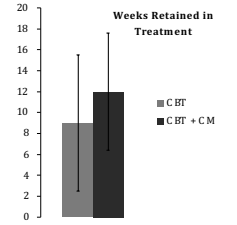


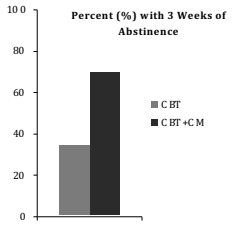


Petry, Pierce, et al. (2005)

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CM is an Evidence-Based Practice

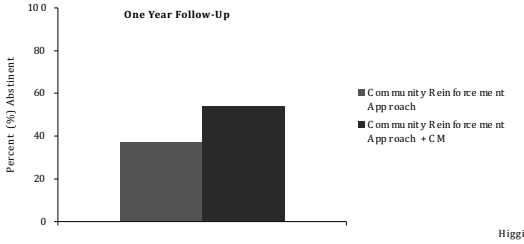




Rawson, et al. (2006)

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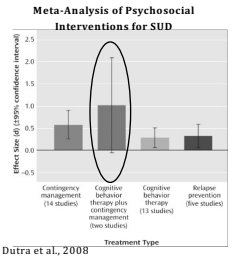
What happens after CM ends?



Higgins, et al. (2000)

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Meta-Analyses of CM





Details of CM interventions matter!

Dutra et al., 2008

Lussier et al. (2006)

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Target Behaviors: Reinforcing Abstinence

Cocaine - (Higgins et al., 1994, 2000, 2003, 2007; Silverman et al., 1996, 1999)

Methamphetamines - (Peirce et al., 2006; Petry et al., 2005; Roll et al., 2006; 2007)

Opioids - (Bickel et al., 1997; DeFulio et al., 2021; Jarvis et al., 2019; Marsden et al., 2019; Preston et al., 1998, 2000)

Benzodiazepines - (Stitzer et al., 1992)

Marijuana - (Budney et al., 2000, 2006; Litt et al., 2013)

Nicotine - (Alessi et al., 2008; Roll et al., 1996)

Alcohol - (Brigham et al., 1981; Petry et al., 2000)

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Target Behaviors: Other Health Behaviors

Treatment Attendance

(Ledgerwood et al., 2008; Petry et al. 2001, 2005; Walker et al., 2010)

Engagement in Therapeutic Activities

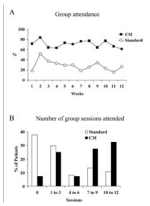
(Iguchi et al., 1997; Petry et al., 2006; Reback et al., 2010)

Medication Adherence

(Haug et al., 2006; Rosen et al., 2007; Petry et al., 2015)

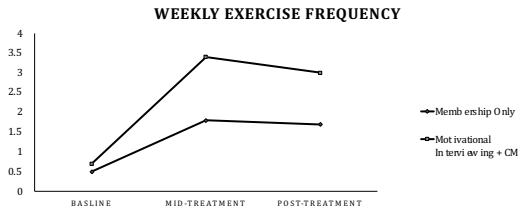
Exercise

(Walker et al., 2010; Weinstock et al., 2011, 2014, 2016, 2020)



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Clinical Trials of CM



Weinstock et al., 2020

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What Populations Respond to CM?

No income effect (Rash et al., 2009, 2013)

No gender effect (Burch et al., 2015; Rash & Petry, 2015)

No race effect (Barry et al., 2009)

- Individuals with greater psychiatric severity tend to do better (Weinstock et al., 2007)

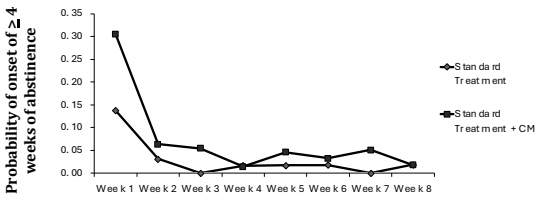
Promotes retention of those with multiple prior treatment admissions (Rash et al., 2008)

See Rash, Stitzer, & Weinstock (2017) and Foster et al (2019) for a review.

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When Do Patients Respond to CM?

Within the first few weeks of being exposed!



Weinstock, Rash, & Petry (2010)

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CM Impacts Other Health Outcomes

In HIV+ individuals with substance use disorders, we reinforced drug abstinence. And, drug abstinence led to:

- Improved CD_4 and viral load counts
- Reductions in HIV-risk behaviors



In sedentary non-treatment seeking individual with alcohol use disorder, we reinforced exercise. Increases in exercise led to:

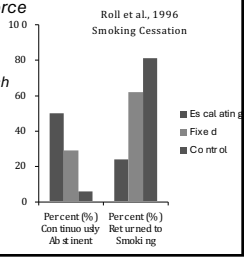
- Reductions in depression
- Reductions in blood pressure

Petry, Weinstock, Alessi, Lewis, & Dieckhaus (2010); Weinstock et al., 2020

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CM Design Considerations

1. *Selecting an objective behavior to reinforce*
2. *Choosing a reinforcer*
   - *Clinic Privileges, Prizes, Gift Cards, & Cash*
3. *Determining monitoring schedules*
4. *Integrating behavioral principles*
   - *Priming, Immediacy, and Escalation*



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Dissemination & Implementation

State Opioid Response Grants

- CM can be used to treatment stimulant use disorder
- $750 cap per patient per year

Indiana SOR

- 14 sites funded to implement CM from residential to FQHC settings
- 7-hour workshop; ongoing TA calls April – Sept (~8 calls;)
- 72 providers trained; 64% of sites launched a CM intervention
- 152 unique clients served over 3 months
- Therapist CM adherence: 85%

Smoker, Weinstock Marriott, Aalsma, & Adams (2024)

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Top 5 Barriers Endorsed by Clinicians

1. Worried about what happens after contingencies are withdrawn
2. Expense - $$$; Who pays for the incentive?
3. Research evidence does not apply to every day clinic populations
4. Sell/trade items for drugs
5. Undermines internal motivation



• These beliefs are modifiable!

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Top Concerns Endorsed by Probation Officers

1. CM prizes do not address the underlying issues (38%)
2. CM programs only reward one behavior and let others slide (38%)
3. CM prizes hurt the treatment process (36%)
4. As soon as prizes go away, they will stop doing the behavior (28%)



• These beliefs are modifiable!

Ryan-Pettes et al. (2023)

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Summary

1. CM is an empirically supported treatment, typically offered as adjunct to other treatments.
2. Helps clients initiate a behavior change that is otherwise very difficult.
3. Provides window of opportunity for other reinforcers and skills to become ingrained.
4. Dissemination of CM is a work in progress!

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Thank you!

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